

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

02914

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County... Green Anne
 City or town... Hean Church Steel
 (If outside city or town limits, write RURAL and give nearest town)
6 weeks
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... W. Virginia County... Raleigh
 City or town... Beckley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Norman H. Atkins

3. (b) Social Security Number

4. Sex... male 5. Color or race... white 6. (a) Single, married, widowed, or divorced... married
 6. (b) Name of husband or wife... Ethel Atkins
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... Feb. 27 - 1891
 8. AGE: Years... 55 Months... 0 Days... 14 If less than one day... hrs. min.

9. Birthplace... West Virginia
 (Town, county, and state)
 10. Usual occupation... Mechanic
 11. Industry or business
 12. Name... Erin Atkins
 13. Birthplace... West Virginia
 14. Maiden name... Nora Simmons
 15. Birthplace... West Virginia

16. Informant... Mrs. Norman Atkins
 Address... Church Hill Ind. - R.F.D.
 17. Burial... Burial Date thereof... Mar. 14 - 1946
 (Burial, cremation, or removal) (Which?) (month) (day) (year)
 Cemetery or crematory... Beckley Cem.
 Location... Beckley, W. Virginia
 18. Funeral director... Edgar L. Lane
 Address... Church Hill Ind.
 19. March 11, 46 Edgar L. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 11 19... 46 at 4:12 p M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 11 19... 46 to March 11 19... 46
 and that I last saw him... alive on March 11 19... 46
 Immediate cause of death... Cerebral haemorrhage DURATION... 1 hour
 Due to... Hyper tension Corda
Vascular disease
 Due to... Generalized Arterio
Sclerosis
 Other conditions... none
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... J. R. Layton MD
Centerville Ind M. D. or other
 Address... Date signed... 3-11-46

RECEIVED

MAR 19 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH
of birth of deceased is shown on 2411 N. Charles St., Baltimore

Dr C. Rodney Layton
Centerville Md
Reg. Dist. No. 254
02515

FILM No. I O 4 MAY 22 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Queen Anne
City or town... Queenstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md. County... Queen Anne
City or town... Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Inez Bolden

3. (b) Social Security Number

none

4. Sex Female 5. Color or race Colored 8.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife John Bolden

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1911 8.(c) If alive, give age 37 years

8. AGE: Years 37 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER 12. Name Dwight Wilson

13. Birthplace Krasoville Md.

14. Maiden name Florence Wilson

15. Birthplace Queenstown Rural Md

16. Informant Ophelia Thomas

Address Turlock, Md.

17. Burial Date thereof Mar 24 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bryan's Chapel Churchyard

Location Centerville Md

18. Funeral director John D. McEligant

Address Easton Md.

19. March 24 46 Helen M. Adridge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 19 46 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 44 to March 21 19 46
and that I last saw him alive on March 21 19 46

Immediate cause of death Coronary Atherosclerosis DURATION 46

Due to Plumetia 12 yrs

Due to Heart Failure 12 yrs

Other conditions Chronic Laryngitis 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. R. Layton M. D. or other

Address Centerville Md Date signed 3-27-46

RECEIVED

MAR 28 1946

BUREAU V S

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

02916

Reg. Dist. No. 251

1. PLACE OF DEATH

County SevierCity or town Sevier
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:
Sevier

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Sevier County SevierCity or town Sevier
(If outside city or town limits, write RURAL and give nearest town)Street No. 926
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Abraham L. Brooks

3. (b) Social Security Number

4. Sex Male 5. Color or race Caucasian 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Leah E. Brooks7. Birth date of deceased (mo., day, yr.) Aug. 20, 1867 6. (c) If alive, give age 78 years8. AGE: Years 78 Months 6 Days 27 If less than one day hrs. min.9. Birthplace Sevier, Tenn.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Leah E. Brooks13. Birthplace Sevier, Tenn.14. Maiden name Leah E. Brooks15. Birthplace Sevier, Tenn.16. Informant Edgar L. LaneAddress Sevier, Tenn.17. Burial (Burial, cremation, or removal (Which?)) Burial Date thereof Mar. 19, 1946
(month) (day) (year)Cemetery or crematory Rossville Cem.Location Rossville, Ind.18. Funeral director Edgar L. LaneAddress Church Hill Ind.19. Mar. 18 19 46 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 46 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sevier, Tenn. to Sevier, Tenn. and that I last saw him alive on March 17 19 46Immediate cause of death Stroke DURATION 3 mosDue to StrokeDue to StrokeOther conditions Stroke

(Include pregnancy within 3 months of death)

Major findings of operations StrokeDate of op. Mar. 18Autopsy results Stroke

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Stroke Date of Mar. 17Where did injury occur? Sevier, Tenn. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) StrokeMeans of injury Stroke Injured at work? Stroke23. SIGNATURE Edgar L. LaneAddress Sevier, Tenn. Date signed Mar. 18

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 9 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

CERTIFICATE OF DEATH

02917

Reg. Diat. No. 251

1. PLACE OF DEATH:
 County St. Anne's
 City or town Chesapeake Beach Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Seven years
 Hospital, institution, or street address where death occurred:
None
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County St. Anne's
 City or town Chesapeake Beach Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME
Elva Belle Carter

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Levin J. Carter

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1875 8. (c) If alive, give age None years

8. AGE: Years 70 Months 5 Days 28 If less than one day None hrs. None min.

9. Birthplace Continued on next page
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name None

13. Birthplace None

14. Maiden name None

15. Birthplace None

16. Informant Church Hill Md

Address Church Hill Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar. 27, 1946
 (month) (day) (year)

Cemetery or crematory Chestertown Cem.

Location Chestertown Md.

18. Funeral director Edgar H. Lane

Address Church Hill Md.

19. Mar. 25, 46 Edgar H. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1946 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1935 to March 24, 1946 and that I last saw him alive on March 23, 1946

Immediate cause of death Myocardial infarction DURATION None

Due to Coronary atherosclerosis

Due to None

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Edgar H. Lane M.D. or other None

Address Church Hill Md Date signed March 25, 1946

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 9 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02918

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Greenland
 City or town Church Hill Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:
W
 How long in hospital or institution? W

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Greenland
 City or town near Church Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Napoleon Cole
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

3. (b) Social Security Number

6. (b) Name of husband or wife

Anna Cole
 7. Birth date of deceased (mo., day, yr.) Jan 23, 1861 6. (c) If alive, give age _____ years

8. AGE: Years 84 Months 5 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace

Greenland Ind.
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

MOTHER

12. Name Samuel Cole

13. Birthplace Greenland Ind.

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant

Edgar Lane

Address Church Hill Ind.

17. Burial

(Burial, cremation, or removal. Which?) Burial Date thereof Mar 22 1946
 (month) (day) (year)

Cemetery or crematory Crumpton

Location Crumpton Ind.

18. Funeral director Edgar L. Lane

Address Church Hill Ind.

19. Mar 22 1946 Edgar L. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to July 19 1946
 and that I last saw him alive on July 18 1946

Immediate cause of death

Decomposed, valvular disease of heart

Due to Chronic myocarditis

Due to Grav. Arterio Sclerosis

Other conditions Stroke

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE @ N. Whitcalf M. D. or other

Address Church Hill Ind. Date signed 3/22/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 9 1946

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83-2)

02919

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne
 City or town Centerville B. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Queen Anne
 City or town Centerville B. D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Prosetta Deaton

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Clarence Deaton
 B. (c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) Aug 1889
 8. AGE: Years 56 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Queen Anne
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business

MOTHER FATHER
 12. Name Hensley Downs
 13. Birthplace G. A. Co
 14. Maiden name Sarah Downs
 15. Birthplace G. A. Co
 16. Informant Clarence Deaton
 Address Centerville B. D.
 17. Burial Date thereof Mar 6 - 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Burville
 Location Burville Ind
 18. Funeral director Edgar & Lane
 Address Church Hill Ind
 19. 3-6-46 Elie Armstrong
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3rd 1946 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12 1946, to Mar 3 1946
 and that I last saw him Mar 12 1946 alive on

Immediate cause of death

Paralysis

Due to

Due to

Other conditions

(to include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. S. McPherson M. D. or other
 Address Burville Ind Date signed 3/6/46

STATE OF MARYLAND

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

SEX

DATE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

REGISTERED MEDICAL EXAMINER

SIGNATURE

RECEIVED

MAR 9 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B2*

CERTIFICATE OF DEATH

02920 252
Reg. Dist. No.

1. PLACE OF DEATH:

County *Queen Anne's*
City or town *P.O. Queen Anne's*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *as to age*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Queen Anne's*
City or town *P.O. Queen Anne's*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *210*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lorenzo James Everingham

3. (b) Social Security Number

none

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Mary Priscilla Wellough*

7. Birth date of deceased (mo., day, yr.) *Oct - 6 - 1868* 6. (c) If alive, give age years

8. AGE: Years *77* Months *5* Days *0* If less than one day hrs. min.

9. Birthplace *Queen Anne's Co. Maryland*
(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

12. Name *William Martin Everingham*

13. Birthplace *Queen Anne's Co. Md*

14. Maiden name *Sarah Callaway*

15. Birthplace *Queen Anne's Co. Md*

16. Informant *Lorenzo Dew Everingham*

Address *P.O. Queen Anne's Md*

17. Burial Date thereof *Mar 8. 46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Chestersfield*

Location *Centerville Md*

18. Funerary director *Barton Bros*

Address *Centerville Md*

19. *3-8-46* *Elie Armstrong*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 5* 19 *46* at *7-40* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct 1 -* 19 *45* to *March 5 -* 19 *46*

and that I last saw him alive on 19

Immediate cause of death

Chronic Interstitial Nephritis

Due to

Due to

Other conditions *Mitral Regurgitation*

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. H. Fisher*

Address *Centerville Md*

Date signed *3/6-46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA

RECEIVED
MAR 11 1946
BUREAU T.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92-b)

02921

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH

County Queen Anne'sCity or town Middletown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 monthsHospital, institution, or street address where death occurred:
Proctor's nursing homeHow long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CecilCity or town RD Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

George F. Hurley

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 13 18758. AGE: Years 70 Months 10 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired telephone line

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs Lilla BaileyAddress P.O. Middletown Del17. Burial Date thereof 3/6/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery Lake SideLocation Lower Rd18. Funeral director Edward BellourAddress Millington Md19. March 5 19 46 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 46, at 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1st 19 46 to March 3rd 19 46and that I last saw him alive on March 3rd 19 46Immediate cause of death Myocardial Infarction

DURATION

1 moDue to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. L. Caplan M. D. or other _____Address Millington Date signed March 5 46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

MAR 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH

County Queen Anne's
 City or town Rural Millington
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Albert Jones

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Louise Jones
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 20 1897
 8. AGE: Years 48 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Millington Md.
(Town, county, and state)10. Usual occupation Painter

11. Industry or business _____

12. Name Corbet Jones13. Birthplace Delaware14. Maiden name Jennie Baker15. Birthplace Phila. Pa.16. Informant James JonesAddress Millington Md.17. Burial Date thereof 3/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MillingtonLocation Millington Md.18. Funeral director Edward KellowAddress Millington Md.19. March 8 1946 Edgar R. Lane
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen Anne's
 City or town Rural Millington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 44 to July 5 19 46
 and that I last saw him alive on July 5 19 46

Immediate cause of death Acute Cardiac Disturbance DURATION _____Due to Myocardial InfarctionDue to Chronic Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edgar R. Lane M. D. or other _____Address Millington Md. Date signed 3/8/46

RECEIVED
MAR 19 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(183)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County... Queen Anne
 City or town... Rural - Church Hill
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frank B. Kennard

3. (b) Social Security Number

213-18-4960

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Separated

6. (b) Name of husband or wife... Clara Kennard

7. Birth date of deceased (mo., day, yr.) July 1, 1892
 6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day
53 8 6 ... hrs. ... min.

9. Birthplace... Kent Co. Maryland
 (Town, county, and state)

10. Usual occupation... Stone Mason

11. Industry or business

12. Name... Joseph A. Kennard13. Birthplace... Maryland14. Maiden name... Mary C. Boone15. Birthplace... Maryland16. Informant... Mrs. Wm. BenjaminAddress... Cannon St. Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof... Mar. 12, 1946
 (month) (day) (year)

Cemetery or crematory... Chester Cem.Location... Chestertown - Kent Co. - Md.18. Funeral director... J. Willis WellsAddress... Chestertown, Maryland

19. Mar. 11 19 46 Edgar L. Lane
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent

City or town... Chestertown
 (If outside city or town limits, write RURAL and give nearest town)

Street No...
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 7 - 1946 at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death... Strangled DURATION

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of... 3/7-46

Where did injury occur? near Chester Hill
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of Injury Injured at work?

23. SIGNATURE... W. Henry FisherAddress... Chestertown Date signed... 3/11-46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94-a)

CERTIFICATE OF DEATH

02924

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
City or town Queen Anne's
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Caroline
City or town Yeads P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

J. Frank Lane

3. (b) Social Security Number

4. Sex m 5. Color or race w. 6. (a) Single, married, widowed, or divorced widowed.

6. (b) Name of husband or wife Margaret Lane

7. Birth date of deceased (mo., day, yr.) Oct 19, 1881 8. (c) If alive, give age years

8. AGE: Years 64 Months 4 Days 13 If less than one day hrs. min.

9. Birthplace Temperville Caroline Md.
(Town, county, and state)

10. Usual occupation Automobile Dealer.

11. Industry or business

12. Name James A Lane

13. Birthplace Md.

14. Maiden name Rebecca Merchant

15. Birthplace Md.

16. Informant J. Frank Lane Jr

Address Yeads P.O. Md

17. Burial, cremation, or removal, which? Burial Date thereof 3/3/46
(month) (day) (year)

Cemetery or crematory Yeads P.O.

Location Yeads P.O. Md

18. Funeral director Raymond B. Pawlinsky

Address Yeads P.O. Md

19. 3-3- 19 46 Elin Armetray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 46, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 46 to March 1 19 46
and that I last saw him alive on March 1 19 46

Immediate cause of death Coronary Thrombosis

Due to Coronary Artery Disease
periton

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herb Lederer M.D.

M. D. or other

Address Chesapeake Date signed 3/2/46

MARGIN RESERVED FOR BINDING

VS 1A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

02925

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH: *Queen Anne*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*MD* County.....*Queen Anne*
 City or town.....*New Church Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Curtis McClain*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *About Knives*

7. Birth date of deceased (mo., day, yr.) *June 25 - 1894*

8. AGE: Years *51* Months *8* Days *10* It less than one day
 hrs. min.

9. Birthplace *Smymna Del.*
 (Town, county, and state)

10. Usual occupation *Laborer*

11. Industry or business

FATHER 12. Name *Wm Thomas McClain*
 13. Birthplace *Del.*

MOTHER 14. Maiden name *Mary E. Jacobs*
 15. Birthplace *Del.*

16. Informant *Wm McClain (in law)*
 Address *Wilm Del.*

17. *Burial* Date thereof *Jan. 16 - 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Smymna Cem.*
 Location *Smymna Del.*

18. Funeral director *Edgar R. Lane*
 Address *Church Hill Ind.*

19. *Mar. 11* 19 *46* *Edgar R. Lane*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 7* 19 *46* at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw h..... alive on 19.....

Immediate cause of death *Drowned*

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *3/7-46*
 Where did injury occur? *New Church Hill Md.*
 (City & town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. H. Foster*
 Address *Centerville Md.* Date signed *3/11-46*

RECEIVED

MAR 19 1946

BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

02926

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queens Queens QueensCity or town Queens Queens Queens
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yearsHospital, institution, or street address where death occurred:
Home

How long in hospital or institution?

3. (a) FULL NAME

Killa Mina Porter

4. Sex

Female White

5. Color or race

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife William J. Porter

7. Birth date of

deceased (mo., day, yr.)

July 20, 1864

B. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

81512hrs.min.

9. Birthplace

Queens Co. Maryland
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER

12. Name

Robert Smith

13. Birthplace

D. D. Co. Md

MOTHER

14. Maiden name

Mary Hopkins

15. Birthplace

D. D. Co. Md

16. Informant

Address

Mrs. Miss PorterRock Hill Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar 14 - 46
(month) (day) (year)

Cemetery or crematory

Chesters

Location

Chestertown Md

18. Funeral director

Address

Edgar L. LaneChurch Hill

19.

(Date rec'd by registrar)

March 13 46Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 4:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 13 1946 to Mar 11 1946and that I last saw him alive on Mar 11 1946

Immediate cause of death

Cerebral hemorrhage
Cerebral infarction

DURATION

14 hours

Due to

Due to

Other conditions

Astoria pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank M. Smith

M. D. or other

Address Chestertown Md Date signed 3/13/46

RECEIVED

MAR 19 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02927

Reg. Dist. No.

254

1. PLACE OF DEATH:

County Queen Anne's
 City or town Narrows, Rural Chester Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Rural Chester Maryland
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Steven H. Sloan

3. (b) Social Security Number

212-16-5306

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Do not know

6. (c) If alive, give age

1886

7. Birth date of

deceased (mo., day, yr.)

?

?

8. AGE:

59

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Do not know

(Town, county, and state)

10. Usual occupation

Oyster schooner

11. Industry or business

Do not know

FATHER

12. Name

Do not know

13. Birthplace

" " "

MOTHER

14. Maiden name

Do not know

15. Birthplace

" " "

16. Informant

Hilton C. Harris

Address

Chester, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar 16-46
(month) (day) (year)

Cemetery or crematory

Colored Methodist Church

Location

Chester Maryland

18. Funeral director

Barton T. Davis

Address

Centerville, Md.

19. Mar. 14

(Date rec'd by registrar)

19 46

N. M. Aldridge

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 13, 46, 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 11, 1946, to March 13, 1946

and that I last saw him alive on

DURATION

Immediate cause of death

Pneumonia

Due to

Due to

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Steven H. Sloan
 Address Centerville, Md. Date signed 3/14/46

RECEIVED

MAR 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

mi.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her alive on

Immediate cause of death

Other conditions

(Include pregnancy within 6 months of death)

Major findings of operations

Antemortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

M. D. or other

3/10/46

RECEIVED

MAR 19 1946

BUREAU

Evidence for change of age of deceased is shown on **MARYLAND STATE DEPARTMENT OF HEALTH**
2411 N. Charles St., Baltimore 10

02929

FILM No. I O 1 APR 15 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:
County..... Queen Anne's
City or town..... Steddersville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Queen Anne's
City or town..... Steddersville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Charles Teat

3. (b) Social Security Number

4. Sex Male **5. Color or race** White **6. (a) Single, married, widowed, or divorced** Widowed
6. (b) Name of husband or wife Emma

7. Birth date of deceased (mo., day, yr.) June 7 1870 **6. (c) If alive, give age** years

8. AGE: Years 76 Months 75 Days 17 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James Teat

13. Birthplace Maryland

14. Maiden name Ezibeth Teat

15. Birthplace Maryland

16. Informant Mrs. Carroll Jackson

Address Steddersville Md.

17. Burial Burial **Date thereof** 3/27/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Steddersville

Location Steddersville Md.

18. Funeral director Raymond B. Rawlings

Address Edensboro Md.

19. (Date rec'd by registrar) Mar. 26 1946 **Registrar** Edgar L. Lane

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24 19 46 at 1140 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 24 to Mar. 24 19 46 and that I last saw him alive on Mar. 24 19 46

Immediate cause of death Cardiovascular

Due to Stroke

Due to Pneumonia

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No **Date of**

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Truck **Injured at work?** No

Signature Tracy H. Hines **M. D. or other** MD

Address Steddersville Md. **Date signed** Mar. 26 1946

MARGIN RESERVED FOR BINDING

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VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 9 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, (92d)

CERTIFICATE OF DEATH

Reg. Dist. No. 02930-252

1. PLACE OF DEATH:

County Queen AnneCity or town Burtholme
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen AnneCity or town Burtholme
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Josephine Thomas

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Howard Thomas7. Birth date of deceased (mo., day, yr.) Dec. about 1870 8.(c) If alive, give age 68 years8. AGE: Years About 20 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Queen Anne Md
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business _____

12. Name Oliver Hard13. Birthplace Md14. Maiden name Wabson15. Birthplace Takron16. Informant Virginia SmithAddress 1938 W. Jefferson ST Phila17. Burial Date thereof April 4-46
(Burial, cremation, or removal) (Which) (month) (day) (year)Cemetery or crematory CentervilleLocation Centerville Md18. Funeral director Chapman & LaneAddress Church Hill Md19. Apr. 4- 1946 Elie Armetrang
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1946 at 1 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1946 to 3/31 1946and that I last saw him alive on 2-30 1946Immediate cause of death Valvular disease of the heartDue to hypertensionDue to hypertension

Other conditions _____

(Include pregnancy within 2 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE J. H. W. Thomas M. D. or otherAddress Burtholme Date signed 4/3/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 15 1946

BUREAU V.S.